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Power to the People

The mutual future of our National Health Service

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About ResPublica

The ResPublica Trust is an independent, non-partisan think tank. We focus on developing practical solutions to enduring socio-economic and cultural problems in the UK. Our ideas are founded on the principles of a post-liberal vision of the future which moves beyond the traditional political dichotomies of left and right, and which prioritise the need to recover the language and practice of the common good.

Based on the premise that human relationships should once more be positioned as the centre and meaning of an associative society, we aim to foster a 'one nation' approach to social and economic inequality so that the benefits of capital, trade and entrepreneurship are open to all. A vibrant democracy and market economy require a stronger focus on virtue, vocation and ethos. Consequently our practical recommendations for policy implementation seek to strengthen the links between individuals, institutions and communities that create both human and social capital, in order to achieve a political space that is neither dominated by the state nor the market alone.

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Executive Summary

The National Health Service is at a critical juncture in its long and illustrious history. Tighter public finances brought about by the most significant programme of fiscal contraction for a generation, together with an ever-ageing population, mean that the current system of healthcare enjoyed by all in England is simply unsustainable. Add to this the stark rise in those suffering from complex and long-term conditions, which are also closely associated with ageing, and the system under which our health system functions will clearly need to be radically reformed. Indeed, long-term conditions will alone bankrupt the NHS if a more effective means of tackling these conditions is not devised, with a funding gap of £19 billion just as a result of these chronic conditions projected within the decade if health spending remains frozen in real terms.

Unfortunately, the NHS, which was established to combat acute diseases like tuberculosis or polio, is simply not designed to treat those with the modern chronic conditions associated with ageing and flawed lifestyle choices. It has long been proven that the most effective way of treating these more complex conditions is to provide whole-person care that caters for the needs of the patient in a holistic fashion. For such care to take place, the delivery of healthcare needs to be organised in an integrated fashion so that it is able to cope with the complex and multivariate causes of modern chronic conditions.

The healthcare system as it is currently structured is, however, far too bureaucratic and fractured to cope. The majority of NHS resources are locked-up in hospital settings and little regard has hitherto been given to more integrated forms of healthcare. As such, the type of holistic care needed to combat long-term conditions, and the chronic diseases associated with ageing, remains a distant reality if not a dream.

Having such a fragmented provision of healthcare compounds problem upon problem, increasing the demand that derives from a failure to deal with an issue effectively the when first encountered. Recent analyses suggest that as much as 80 per cent of all A&E submissions were admitted incorrectly due to this 'failure demand', and that many should have been referred to more appropriate settings outside of hospital. Given that almost half of all hospital spend is on A&E, not delivering holistic care has clear health and financial consequences.

In light of the issues surrounding service fragmentation in the NHS, new institutions and structures will need to be installed that deliver better integrated care. Yet there is a noticeable dearth of practical solutions on how to bring about such a transformation. Most purported solutions either espouse further state control, with all the added bureaucracy that comes with this, or for a more prevalent role for the private sector, which risks further service fragmentation through the cherry picking of those most wealthy of patients to the exclusion of the poorest. Neither option alone is a sufficient solution to the problems associated with the chronic conditions of the future, nor can they describe how a seamless NHS could be instituted.

This report argues for a more balanced solution that exemplifies the positive traits of both the public and private models. We believe that mutualism could perform this hybrid role. Health mutuals are owned exclusively by patients, and are naturally democratic and benevolent. As such, they are in a perfect position to offer or co-ordinate integrated care in a collaborative fashion. Not only this, all mutuals operate in the competitive space and could increase patient choice through the imposition of further competition.

Since the introduction of foundation trusts and the emergence of NHS spin-outs, mutualism has had a significant foothold in the NHS. But a mutual model has yet to be developed that can perform the integrating role required to partner and group disparate service providers to deliver whole-person care. One type of mutual organisation that would be ideally placed to play such a role would be the friendly society. Prior to the creation of the NHS, friendly societies dominated the financing of healthcare in England, and have a long history of excellence in the health sector. These mutuals organisations already deliver or facilitate healthcare on behalf of their members in a holistic and integrated fashion, and could perform a much needed integrator role in the centre of the NHS.

This new, mutual-centred model of integrated care would, under the plans detailed in this report, be completely funded within the current efficiency commitments established under the Quality, Innovation, Productivity and Prevention (QIPP) programme, and would realise further savings of £4.5 billion through providing more integrated and community-based services. As part of this new system, a revised role for Monitor would also need to be developed, with a more pro-active role envisaged for the regulator that has integration at its heart.

This system of whole-person, joined-up care would undoubtedly improve the patient experience, improve health outcomes and be much more cost-effective. In order to achieve the integrated system of healthcare outlined in this report, and to promote the mutual organisations needed to facilitate this integration revolution, we recommend that Government and the industry adopt the following eight recommendations.

Summary of Recommendations

1. Instigate an independent review on patient engagement:

Building on the Review initiated by Norman Lamb MP, Minister for Care and Support, and led by Chris Ham on NHS staff engagement, we recommend that the Department instigate a similar review on patient engagement. This review would consider options for supporting the patient voice in the running of NHS services, and would assess the role mutual organisations could play in empowering patients.

2. Establish a Pilot Scheme for the proposed model for integrated healthcare commissioning:

We believe that friendly societies, and other mutuals, could play a valuable role in integrating healthcare services. In order to assess the viability of the proposed mutual integrator model proposed in this report, and to evaluate its efficacy in providing better holistic care, we recommend that the Department of Health establish a Pilot Scheme comprised of 8-10 Clinical Commissioning Groups (CCGs) to determine just this.

3. Re-cast Monitor as the regulator for health service integration:

Under the Health and Social Care Act 2012, Monitor has a duty to “enable” integrated healthcare. But under the NHS Provider License, this so far only extends to allowing Monitor to intervene where providers are acting in a manner that is detrimental to the provision of integrated care. Given the forecasted sharp rise in complex conditions and the increasing need for more integrated care, we believe that this passive approach to regulation should be replaced with a more pro-active approach. We recommend that Monitor be re-cast as the regulator for NHS integration, and that it should proactively police levels of healthcare integration. It could do this either through Ofsted-like inspections and grading; or through well-publicised league tables.

4. Require all CCGs to prioritise prime or alliance contracts:

The fracturing of the NHS services along bureaucratic lines artificially atomises the needs of

patients and ultimately makes holistic care more difficult. To combat this, we recommend that NHS England amend the NHS Standard Contract to ensure that integrated commissioning arrangements, like prime or alliance contracts, are the preferred form of arrangement. All new NHS contracts for the provision of healthcare should have integration and partnership working at their core. Prioritising these types of contracts would both promote more collaborative approaches to healthcare and enable holistic care to take place.

5. Introduce a new Right to Holistic Care:

Patients are often referred on to NHS services by their GP in a confusing and disjointed manner. Patients regularly experience numerous referrals to disparate providers and in a multitude of settings. Referring patients in this manner is inefficient, wastes time and is detrimental to the overall patient experience. In circumstance where patients do not feel that they are receiving a fully integrated service from the NHS, we recommend that they be permitted to activate a new Right to Holistic Care. This would allow the patient, many of whom are older people, to request the establishment of a personalised Whole-Person Care Plan that would map in clear detail the integrated network of services the patients would be able to access, and arrange the referrals of that patient through the system in an efficient and stress-free manner. These Plans could be delivered through Personalised Healthcare Budgets to allow for further streamlining and integration.

6. Scrap the Any Qualified Provider initiative:

This leading private provider scheme allows external providers to deliver basic NHS services, such as physiotherapy and psychotherapy. The AQP initiative is promoted in the name of competition and patient choice. Whilst this is admirable, it does not do little to deal with the issues surrounding service disintegration, and, because AQP merely replicates the divisions already present in the NHS in the private sector, it does not allow for the provision of whole-person care. We recommend that the Department of Health evaluate the effectiveness of this scheme. Competition on the whole is

something to be promoted in the NHS, but not at the expense of collaboration and integration. If AQP is assessed to be overall detrimental to service integration, as we suspect it is, then we recommend that it be scrapped and replaced with a more appropriate scheme.

7. Issue a challenge to friendly societies to diversify their services:

Friendly societies that operate in the health sector offer a mixed-bag of services to their members. Some focus on delivering services to older people and some prefer to focus on wellbeing in the community. In order to operate in the integrator role we recommend in this report, friendly societies will need to increase the amount of services they provide. In order to achieve the role we lay out for them, we suggest that friendly societies in the health sector re-shape themselves as organisations that primarily focus on providing care for older people and those with long-term conditions.

8. Encourage friendly societies from different sectors to enter the health market:

The Association of Financial Mutuals, which represents friendly societies, comprises of 53 full members. The majority of these members do not provide cover for health services as some like Benenden Health do, and instead focus on pensions and savings. Friendly societies have a long and distinguished history of operating in the health sector, and were, prior to the advent of the NHS, the primary vehicle for health funding. We recommend that friendly societies endeavour to re-discover this role by adjusting their product offerings to make them more suitable to the health market. This would both increase competition amongst mutuals and improve patient choice.

We believe that, by adopting these above recommendations, the NHS would become better integrated and more able to meet the challenges presented by an ageing and increasingly unhealthy population. It is the primary proposition of this report that, in order to keep our health system on a sustainable footing, the future of the NHS will undoubtedly need to be more mutual.

1

Introduction

*"An ageing population with more chronic health conditions....means we're going to have to radically transform how care is delivered outside hospitals."*¹

Simon Stevens, Chief Executive, NHS England

The National Health Service is at a crossroads. Tighter health budgets together with an ageing population mean that the way we fund the NHS will need to be drastically reformed if our system of healthcare is to remain viable. Yet, from both ends of the political spectrum there seems to be a shortage of sensible ideas on how to put the NHS on a more sustainable footing. Indeed, many of the arguments surrounding health reform suggest that the solution to this financial crisis is a laughably simple one. One side of the debate argues that greater privatisation needs to be pursued in the name of choice; while the other maintains that the private sector needs to be completely excluded from the NHS to guarantee the universal, free at the point of use nature of our health system.

But these two simple arguments represent a false dichotomy. Across the developed world, including England, the greatest problems currently facing healthcare systems are the related factors of an ever-ageing population and the rise in prevalence of those suffering from long term conditions. These impending dangers will not be solved by simply debating the particular merits of private or public models of healthcare provision. No healthcare system in the world, whether it prioritises the public over the private (or the inverse), has the means of tackling the growing numbers of those who suffer from long-term conditions.

But while no system yet has the adequate means of dealing with these two interrelated and increasing problems, it is generally agreed by all parties that the solution can only be found in the better integration of healthcare. Integrating healthcare delivery and moving away from siloed and fragmented provision is the only suitable means by which to treat those with the complex conditions associated with old age and flawed lifestyle choices. Indeed, developing new strategies to integrate care and combat these new chronic conditions, such as dementia or diabetes, as opposed to those methods of service delivery that treat the acute diseases of the past, like polio or tuberculosis, will be crucial in deciding whether the NHS remains viable as a system wholly funded through taxation.

To precipitate such a transformation, the NHS of the future will need to move from a system that deals with the siloed needs of patients, shaped by the bureaucratic processes of a tangled and atomistic system, to a holistic form of care that caters for the needs of the patient in the round. This move from remedial care to whole-person care will require a comprehensive shift in all aspects of NHS structure, management and culture. As it currently stands, most NHS contracts, staff and financial resources are locked-up in hospital and acute settings. In order to focus on the holistic needs of patients, healthcare will need to be delivered in a more integrated fashion, and often outside of hospital settings and much closer to home.

All hospitals, for reasons of specialisation, treat patients based on particular sets of symptoms or for specific illnesses. This

in itself is not a problem, as clinicians need to specialise in order to refine and improve medical practices. But this hospital-dominated system of care is mostly designed to cater for acute illnesses or surgery. It is not designed to combat lifestyle diseases and other conditions of a complex and multivariate nature. The holistic approach to healthcare needed in order to treat these conditions by engendering lifestyle change and supporting personal responsibility, cannot be provided effectively in a hospital setting.

Patients with more diverse needs, including those with long-term conditions, need to have their overall health and wellbeing needs assessed. For this to happen effectively, many services will need to be transferred from acute settings into the community or managed seamlessly through integrated care pathways that are patient-led. But under current NHS funding arrangements, the funding required to combat chronic conditions is tied-in to hospital contracts and is disintegrated from other sections of the health system, be that public or private, community or at home. Undoing this organisational disarray would require, at least in part, the finances for healthcare provision to be transferred away from hospitals and towards more appropriate settings. Only then could holistic, whole-person care become possible.

Given the inevitable shift in emphasis from acute to chronic that is required, the NHS as it currently exists is clearly not fit for purpose or on a financially sustainable footing. On current projections, long-term conditions alone will bankrupt the health

system within a decade, irrespective of any provision for emergency care. Together the four combined vectors of an ageing population; a steady increase in the cost of drugs; a surge in those suffering from long-term conditions; and decreasing health budgets, all mean that the NHS is barely able to match present demands, let alone meet future burdens.

What is needed is a new system of healthcare that delivers personalised, holistic care in a cost-effective manner. Yet despite popular political opinion, the solution to providing such care cannot be found in purely public or private models of healthcare. The public sector has a tendency to be fragmented, overly-bureaucratic and process-driven rather than patient-led; and the private sector also risks fragmenting service provision, not least because private insurance naturally precludes the poorest from fully benefiting. It is axiomatic that holistic care, which is what patients will increasingly require, can only be delivered through integrated health services. If the provision of healthcare is siloed along bureaucratic lines or fragmented due to competitive pressures, then care will become fractured and the diverse needs of the patient artificially atomised.

In light of these issues, a new form of institution will be required that can bridge the gap between public and private, and which operates in a facilitating role on behalf of the patient to ensure that the best quality and most appropriate levels of care is provided – regardless of whether the service is provided in a public hospital, private clinic or in the community. Such a degree of integration would allow for more holistic forms of care by permitting the patient to access a whole care pathway, rather than the disjointed and partial system of care that currently confronts them.

To ensure the NHS remains free at the point of delivery and wholly funded through taxation, purely public or private sector options are not suitable for dealing with the pressures of the future. There is, however, an alternative option open to those in

Government, and that is to fully embrace mutualism in the NHS.

Mutualism is the perfect compromise between public and private provision. Mutual and co-operative organisations are, by their very nature, democratic and benevolent institutions. As such, they are perfectly placed to integrate the needs of patients with the capabilities of clinicians in an inclusive fashion. Also, as mutuals are not publicly owned, they are better able to operate in a competitive environment, with mutuals competing against each other to improve patient choice and increase quality.

Mutualism already has a firm foothold in the NHS. Foundation Trusts, which operate on a mutual model, are now the standard composition for hospitals, and NHS spin-outs, many of which are mutuals, are raising standards of healthcare and patient engagement across the sector. But a mutual model has yet to be developed that can perform the integrating role required to deliver whole-person care. One type of mutual organisation that has often been ignored, but could perhaps perform this vitally important integrator role, is the friendly society.

Britain's friendly societies have a long and distinguished history of financing healthcare in the UK. Before the emergence of the National Health Service in 1945, most healthcare was funded by mutual insurers. In 1910 there were 26,877 mutual societies and 6.6 million registered members, which amounted to 1 in 8 of the population at the time. Even though membership of these organisations has seen a significant reduction since this zenith, millions across Britain still enjoy the benefits of these co-operative and democratic organisations. This level of membership and coverage, alongside the fact that they themselves are not for the most part engaged in the delivery of healthcare and just the organisation or funding thereof, makes them ideally placed to perform the integrating role advocated in this report.

To integrate the care pathway of the patient from entry to exit, friendly societies would, as the new integrator institutions for the NHS, need to be fully partnered with both public and private sector bodies to ensure the smooth, unbroken transition of the patient through the system. Since the introduction of Clinical Commissioning Groups (CCGs) in 2012, such a system of integrated healthcare is now possible.

Throughout this report we, quite rightly in our opinion, argue that the future of the NHS is undoubtedly mutual. The remainder of the report will assess how friendly societies could be promoted to play a much wider role in the provision of NHS services, as well as how they could operate as facilitating organisations in a new NHS that would manage the transition of health services from a siloed system to an integrated, patient-centred system of care. The economic and health benefits of such a revolution in healthcare provision will also feature throughout the report.

1 Wright, O. (2014) "New NHS chief: Stakes have never been higher for service, warns incoming Simon Stevens", *The Independent [Online]*. Available at: <http://www.independent.co.uk/life-style/health-and-families/health-news/new-nhs-chief-stakes-have-never-been-higher-for-service-warns-incoming-simon-stevens-9226893.html> [Accessed 15 April 2014].

2 The system as it stands

“The NHS, which many today categorise as struggling to cope with patient demand, has experienced funding and delivery problems from its very inception.”

The National Health Service in England first opened its doors to patients in July 1948.² The formation of the new health system was one of Britain's grandest post-war projects and was established at the behest of the now famous Beveridge Report. This report had the laudable aim of seeking to tackle the five “Giant Evils” in society: squalor, ignorance, want, idleness, and disease.³ In the post-War settlement, it was thought critical to combating the last of these that the Government establish a National Health Service.

The Labour Government of Clement Atlee set-up the NHS as an institution that was to be funded completely from public expenditure derived from taxation, rather than private insurance. This differed to how systems of universal healthcare were introduced on the Continent, and was intended to ensure that the wealthy contributed more to the new healthcare system than the poor. It was essential to this inclusive model that the NHS was free at the point of delivery, and that treatment would be given at all NHS institutions across the country.

But demand for healthcare under the new system quickly exceeded all expectations. The number of patients recorded on doctors' registers rapidly rose to 30 million. This rise in demand almost immediately had a very noticeable effect on healthcare budgets. The NHS planned for £1m for optometry services in its first year of operation, but within a year 5.25 million spectacle prescriptions had produced a bill totalling £32m. Furthermore, in 1947, GPs were issuing 7 million prescriptions per month, but this had risen to 19 million

per month in 1951.⁴ The NHS, which many today categorise as struggling to cope with patient demand, has experienced funding and delivery problems from its very inception.

In the face of surging demand on the system, successive government from the 1950s onwards have sought to tackle this problem by increasing the levels of funding available for treatments and services, with the number of doctors registered with the NHS doubling between 1948 and 1973. But, as soon became obvious, simply continuing to meet the inexorable demand placed on the NHS through increases in public expenditure was simply unsustainable.

In response to this, during the Governments led by Margaret Thatcher, the pace of public expenditure slowed and NHS liberalisation reforms were introduced. Under these changes, greater powers were given to NHS managers at the expense of civil servants, and what was later to be called the ‘internal market’ was established in law.⁵ Also, competition between providers was introduced and GPs for, the first time, became fund holders.

This process of liberalisation continued into the Labour Government that followed. In the context of the, only then just emerging issues associated with a rapidly ageing population, further competition was promoted within the NHS and patient choice became the centre piece of a raft of new reforms. Outsourcing of medical services and support to the private sector was encouraged and the Private Finance Initiative saw an increasing number of hospitals built by the private sector.

Yet still, these liberalisation reforms and increases in public expenditure were not enough to match increasing demand on NHS services. The current Coalition Government, in response to the failures of previous attempts at reform, undertook what was potentially the greatest change in the National Health Service since its creation in 1946. The “Lansley Reforms”, as they became known in reference to the then Health Secretary, are contained within the Health and Social Care Act 2012.

The key aims of the original Bill were to give GPs control of commissioning through the introduction of GP-led Clinical Commissioning Groups (CCGs); re-cast Monitor, which had previously overseen the regulation of Foundation Trusts, as the regulator for economic performance; and change the classification of all hospital trusts to mutual Foundation Trusts.⁶

These reforms were intended to empower GPs and increase patient choice, but they were met with significant opposition. The Royal College of General Practitioners (RCGP) urged the Secretary of State to scrap the reforming of Monitor. It suggested that Monitor’s new responsibilities would increase the use of market forces in health, even though there is little evidence that it improves quality of care.⁷ The RCGP suggested that instead of adopting a market-led approach, the Department of Health look to a system that focuses on promoting integration, co-operation and collaboration, rather than have competition as its centre-piece.⁸

The Royal College of Physicians (RCP) also criticised the Bill, albeit from a different angle. The RCP suggested that the Bill would actually make the management of the NHS more bureaucratic. Three layers of management in the NHS would be replaced by six new ones, and a seventh if you count the health and wellbeing boards to be established at the local authority level.⁹ Similar concerns were raised in a report by the Health Select Committee in 2013. It stated that the abolition of primary care trusts and strategic health authorities had removed some of the system management that had been in place, and had reduced a level of local oversight, which needed to be restored.¹⁰

The general criticism of the new health system, which is still in place, is that it focuses on competition over collaboration and integration; added unnecessary layers of bureaucracy to regulate this added competition; and reduced levels of local accountability in the system. The Government has largely failed to win over the medical profession with its reforms and there is doubt as to whether these reforms are sufficient enough to meet the complex challenges that lie ahead.

“The Government has largely failed to win over the medical profession with its reforms and there is doubt as to whether these reforms are sufficient enough to meet the complex challenges that lie ahead.”

2 Twedell, L. (2008) “The Birth of the NHS – July 5th 1948”, *Nursing Times* [Online]. Available at: <http://www.nursingtimes.net/the-birth-of-the-nhs-july-5th-1948/441954.article> [Accessed 15 April 2014].

3 Beveridge, W. (1942) *Social Insurance and Allied Services*, London: HM Stationary Office, p.6.

4 National Archives (2014) The Origins of the NHS [Online]. Available at: <http://www.nationalarchives.gov.uk/cabinetpapers/alevelstudies/origins-nhs.htm> [Accessed 15 April 2014].

5 National Health Service and Community Care Act 1990.

6 Charlesworth, A. et al. (2013) “The coalition Government’s health and social care reforms”, *Nuffield Trust* [Online]. Available at: <http://www.nuffieldtrust.org.uk/our-work/projects/coalition-governments-health-and-social-care-reforms> [Accessed 14 April 2014].

7 Campbell, D. (2011) “Lansley health reforms may wreck NHS, doctors warn David Cameron”, *The Guardian* [Online]. Available at: <http://www.theguardian.com/society/2011/may/09/reforms-wreck-nhs-doctors-warn> [Accessed 15 April 2014].

8 Campbell, D. (2011) “Lansley health reforms may wreck NHS, doctors warn David Cameron”, *The Guardian* [Online]. Available at: <http://www.theguardian.com/society/2011/may/09/reforms-wreck-nhs-doctors-warn> [Accessed 15 April 2014].

9 Nicholl, D. (2012) “The NHS bill is beyond repair”, *The Guardian* [Online]. Available at: <http://www.theguardian.com/commentisfree/2012/feb/27/royal-college-of-physicians-nhs-bill> [Accessed 15 April 2014].

10 Clover, B. (2013) “MPs criticise Lansley reforms over A&E problems”, *Health Service Journal* [Online]. Available at: <http://www.hsj.co.uk/acute-care/mps-criticise-lansley-reforms-over-ae-problems/5061542.article> [Accessed 15 April 2014].

3 Why the NHS is on an unsustainable footing

"Given that the NHS currently serves the health needs of over 60m people, and this is set to rise to over 70m by 2020, these burdens are only ever going to get worse."

The last 40 years has seen endless reorganisations of the NHS. Some of these have been radical overhauls, some merely cosmetic. A routine analysis of the size of healthcare system will make it clear why England's health service is deemed overly-bureaucratic and why, despite numerous attempts over the decades, the NHS is still in need of more reform.

There are few global organisations that directly employ 1.4 million people, and the NHS is the largest single organisation in Europe. Given that the NHS currently serves the health needs of over 60m people, and this is set to rise to over 70m by 2020, these burdens are only ever going to get worse. As was detailed above, the last decade has seen an escalation in attempts at service reform.

The scale of the challenge posed to those in Government can be seen from the statistical snapshot of the NHS featured on the opposite page.¹¹

Clearly, generating efficiencies and driving change through such a large and complex organisation is fraught with problems. Simply put, there are too many hospitals delivering expensive acute care but not enough capacity in the system for more effective community-based healthcare solutions. The primary/secondary care divide makes emergency admission too common a way to access hospital services. This is expensive, inefficient and traumatic for the patient. Yet it allows hospitals to dominate the NHS power structure.

Integrated care would be the ideal solution to this, particularly in light of the four factors that combined would make the NHS as it is currently structured financially unsustainable. To repeat, these are decreasing public health budgets; increasing costs associated with drugs and surgery; a rapidly ageing population; and a dramatic increase in the prevalence of those with long term conditions (LTCs).

How each of these factors and the impact each will have on the NHS will now be considered seriatim.

Decreasing public health expenditure

Spending on the NHS has grown dramatically since its inception in 1948. Spending ran at about 3.5 per cent of GDP during the early years of the NHS, but by 1978 spending had risen to 5 per cent of GDP.¹² Public expenditure on the NHS peaked during the 2007-08 period before the recession at 7.9 per cent of GDP. Leading up to this zenith, the growth rate in expenditure had accelerated. From the period 1996/97 to 2009/10, the NHS witnessed an average annual funding increase of 6.4 per cent per annum.¹³ This was, as policy makers and clinicians know now, an unsustainable trend.

The increase in the proportion of GDP spent on health in the UK has been broadly similar to the average increases recorded by other OECD countries. Health spending in the UK has risen from 3.9 per cent in 1960 to around 7.5 per cent today. In the OECD

The NHS deals with 88 million outpatient appointments every year.

88 million NHS outpatients



The combined populations of:



The NHS sees in 36 hours the equivalent of all those who attended premier league football games in a month

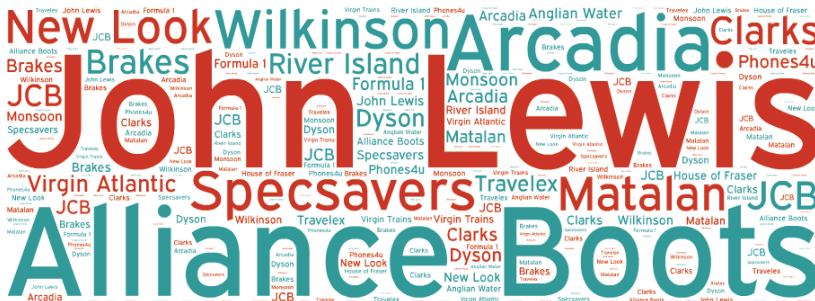
1 million patients every:



Attendance of 30 premier league games



The NHS employs 1.4 million people. This is more than double the entire head counts of the entire top 100 privately owned companies, including:



it has equally risen by an average of 3.8 per cent over the same time period. This demonstrates that the funding pressures that face the healthcare system in England are very similar to those encountered in other parts of the developed world, and are unlikely to go away any time soon. In total, the government spent almost £450 billion on all public services in 2010/11; over a quarter of which (27 per cent) was spent on the NHS in England, this is compared to 17 per cent three decades previously.¹⁴

But this period of rapid growth in public health expenditure has now come to a halt. With the current economic crisis leading to fiscal consolidation in the UK, resuming the historical growth rate in NHS funding looks

unrealistic in the short term, let alone in the longer term. In total, as set out in the 2010 Spending Review, public spending is to be reduced by £81 billion in real terms over the length of the parliament.

This equates to an average fall in total public spending of 2.1 per cent a year over this period. Against this backdrop, the NHS in England has done well under the real-terms spending cap, with funding set to increase by an average of 0.1 per cent a year in real terms. In contrast, other public services will have their funding reduced by an average of 2.9 per cent a year in real terms. Given the historic growth rate of the NHS, this represents the tightest period in fiscal contraction over the past 50 years.¹⁵

Clearly, as England's population grows, the need for healthcare will rise commensurably. Additionally, a population with a greater proportion of older people will have a greater need for healthcare. According to the Office for National Statistics (ONS), the overall population for England is projected to grow by over four million people, from 52.1 million (49.3 per cent male) in 2010 to 56.4 million (49.6 per cent) in 2021, and is expected to be close to 70 million by 2030.¹⁶ This increase is greater than the current total population of Wales.

Funding pressures on acute services will rise by just over one per cent a year between 2010/11 and 2021/22 as a result of population change in line with the ONS projection alone. The increase in hospital admissions for patients with chronic conditions, without the population growth effect, will result in increased funding pressure on acute services of over one per cent a year across the same period. The combined effect of population change and rising admissions for chronic conditions will result in total pressure on acute services in England rising by three per cent every year in real terms.¹⁷

Furthermore, a continued real-terms freeze in the NHS allocation after 2014/15 will result in a funding gap of £28 to £34 billion in real terms in 2021/22. This would require savings of at least four per cent a year over a decade, including the period between 2010/11 and 2014/15.¹⁸ Simply making efficiencies and managing chronic conditions will be sufficient to close the funding gap if funding grows in line with GDP, but this will not be the case if spending is frozen in real terms after 2014/15. A gargantuan gap of between £16 and £19 billion is to be expected in 2021/22.¹⁹ Clearly, urgent action is needed if the NHS to remain a health service almost completely funded through taxation.

The rising costs of medication and surgery

As medical science has become more advanced, so too have the costs of procuring medicines and surgical operations increased. For drugs, the net ingredient cost per head per prescription in 2011 was £169, up from £113 in 2000. Latest figures suggest that GPs issue 886 million prescription items each year, costing £8.5

billion (approximately 15 per cent of NHS costs).²⁰ Further, from the years 2003–2012, the number of items prescribed per person in England grew from 13.03 to 18.30. That equates to over 1 billion prescriptions in 2012.²¹

This rise in the cost of drugs has been mirrored by rises in the price of prescription charges. In March 2014, the Department of Health announced that NHS prescription charges in England will increase by 20 pence from £7.85 to £8.05 for each quantity of a drug or appliance from 1st April 2014. The single charge is set to increase by 20 pence to £8.25.²²

The Government has made attempts to keep this price inflation in check. In November 2013, the Department of Health announced that the Government and pharmaceutical firms had agreed a new five-year deal to increase the ability of the NHS to use top branded medicine and innovative treatments without costs of these drugs spiralling out of control. Under the Pharmaceutical Price Regulation Scheme, a voluntary agreement between the Department and the Association of the British Pharmaceutical Industry, the bill will not rise over the next two years and then grow less than 2 per cent for the following three. If spending on branded medicine exceeds the allowed growth rates, the industry will make payments to the Department of Health. This replaces a similar agreement that expired in December 2013. With those companies who do not participate in the voluntary agreement, a 15 percent price cut was agreed to make sure that there were safeguards in place for the NHS.²³ This is a welcome move, as the NHS spends more than £12bn on branded medicines each year.²⁴ But these actions alone will not stop long term increases in drug price inflation.

This is particularly true for the complex conditions that will plague the future NHS, like cancer. A report published by BUPA concluded that over the next decade the costs of cancer in the UK will increase from £9.4 billion in 2010 to £15.3 billion by 2021, which is equivalent to an average of £40,000 per person with cancer.²⁵ This will mean a 62 per cent increase in the UK's overall expenditure on cancer diagnosis, drugs and surgical treatment, itself an increase of £5.9 billion compared with the current expenditure.

An ageing population

It is an undeniable fact that Britain is getting older. There will be 51 per cent more people aged 65 in 2030 than there was in 2010, and over 100 per cent more people aged 85 and over.²⁶ This point is critical because, without immediate and comprehensive reform, public spending on social care will rise from £14.6 billion in 2010 to £23 billion by 2025. With the number of people in England with moderate or severe disabilities projected to increase by 32 per cent by 2022, the public expenditure on social care and continuing healthcare for older people will have to rise to £12.7 billion in real terms just to keep pace with expected demographic and unit cost pressures.²⁷

To put that problem into perspective, if the English NHS achieves unprecedented productivity gains of 4 per cent a year in every year from 2010–15, this funding gap is predicted to be reduced to a potential shortfall of £34 billion.²⁸ For comparison, the total budget for the English NHS in 2010/11 was £107 billion. If the system did not change and a shortfall on this scale materialised, it would have particularly serious consequences for older people, who are by far the biggest consumers of NHS spending. Projected future expenditure on social care and continuing health care will vary with future life expectancy. Under the Office of National Statistics low-life expectancy population projection, the number of older people with moderate or severe disabilities is projected to rise by 30 per cent, with public expenditure on social care and continuing health care rising by 35 per cent in real terms between 2010 and 2022. Under current life expectancy projections, the number of older people with moderate or severe disabilities would rise by 34 per cent, with expenditure rising by 40 per cent.²⁹

In addition, if rates of chronic disease continue to rise in line with recent trends, the number of older people with moderate or severe disabilities is projected to increase by 54 per cent, and public expenditure on social care and continuing health care to increase by 56 per cent between 2010 and 2022, to £14.4 billion in real terms. In short, the UK population will increasingly be dominated by older people. This will negatively affect the NHS on a scale never witnessed before, and will place the entire healthcare system under severe, and probably fatal, financial strain.

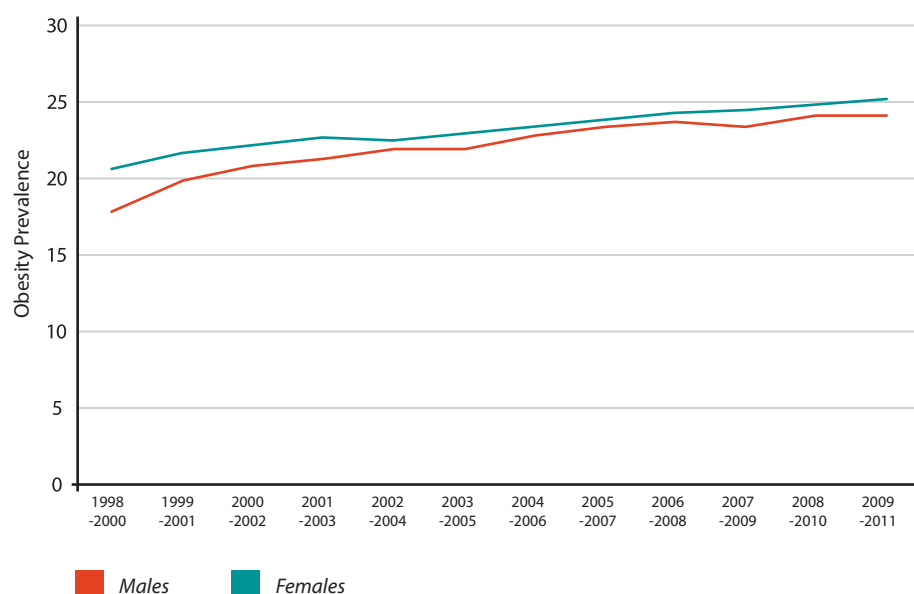
Increase in prevalence of those with long term conditions

Taken together, long term conditions account for a significant proportion of the overall burden of disease in the UK, contributing more than half of the total number of years of life lost due to ill health, disability or early death.³⁰ Around 15 million or 25 per cent of those in England account for around 70 per cent of total NHS spend, which is mainly attributed to caring for people with long term conditions (LTCs).³¹ The number of people with only one LTC is projected to be relatively stable over the next ten years. However, those with multiple LTCs is set to rise to over 3 million by 2020 from 1.9 million in 2008. This statistic alone could bankrupt the NHS unless radical change takes place almost immediately.

The majority of CCG spend is on acute healthcare services. This is inappropriate, given that significant spend in the acute setting occurs as a result of complications and problems arising from the increasing prevalence of one or more long-term conditions, such as obesity, diabetes, cardiovascular disease, cancer, arthritis, dementia, and depression. Such long term conditions are partly preventable through pro-active diet and lifestyle changes. This provides a clear opportunity for improving future healthcare outcomes and reducing demand on the NHS. But it is not completely clear who is responsible for implementing such programmes, and what incentives and penalties could be utilised to shift the mode of healthcare from a fractured to an integrated system of care.

People with long term conditions account for:³²

- 50% of all GP appointments
- 64% of hospital outpatient appointments
- 70% of all inpatient bed days
- 70% of the total health and care spend in England (£72m)
- 15 million people in England – therefore 30% of the population account for 70% of spending

Fig. 1 Trends in Obesity Prevalence in Adults (16+) ³⁴

We will now consider the costs, both human and financial, associated with obesity, diabetes, cancer, cardiovascular disease, dementia, arthritis and depression.

Obesity³³

Obesity is caused by eating too much and exercising too little. It's a simple equation – if you consume high amounts of energy from your diet but do not burn it off through exercise and physical activity, the surplus calories are turned into fat. The average physically active man needs 2,500 calories to maintain a healthy weight, and the average woman 2,000. Obesity does not just happen overnight – it develops gradually from poor diet and lifestyle choices. The world has generally got fatter, which is mainly the result of adopting fast food or high sugar diets and a global reduction in physical activity brought about by workplace automation.

Unhealthy eating habits tend to run in families, as you learn bad eating habits from your parents. Childhood obesity can be a strong indicator of weight-related health problems in later life, showing that learned unhealthy lifestyle choices continue into adulthood. The World Health Organisation use the body mass index (BMI) as a simple index of weight-for-height that is commonly used to classify overweight and obesity in

numbers in a population. It is defined as a person's weight in kilograms divided by the square of his height in meters (kg/m^2). A BMI greater than or equal to 25 is overweight and greater than 30 obese.

The trend in obesity in the UK is alarming both in adults and children. Obesity is associated with diabetes, heart disease, cancer, arthritis and depression so its rising incidence will have a profound effect on the health economy.

Diabetes³⁵

Diabetes is a condition where the concentrations of glucose in the blood are too high as the body cannot process sugar as efficiently as it should. There are two main types of diabetes – type 1 and 2. Type 1, which usually is recognised in childhood, is due to the failure of the pancreas to produce enough insulin. Type 2, by far the common, is when there is not enough insulin or the insulin is there but not working properly. The commonest cause of Type 2 diabetes is obesity. With this condition, the pancreas cannot keep up with the demand for insulin brought about through the overconsumption of food.

The complications of long standing, poorly controlled diabetes are expensive to treat. As well the demands placed on healthcare

services, diabetes is also a huge burden on social care budgets. The main complications associated with diabetes are cardiovascular disease, kidney disease, eye disease, vascular disease, amputation and depression. The prevalence of diabetes in men has increased from 2 per cent of the adult population in 1991 to 6.3 per cent in 2010 – an increase in prevalence of over 300 per cent over that time period.

Cardiovascular disease³⁶

Cardiovascular disease, which includes coronary disease, heart attacks, stroke and heart failure, is a major contributor to chronic disease burden. There has been a dramatic decline in the death rate from heart attacks in both men and women over the last 40 years. This is largely due to better preventive measures, including statin therapy, and better treatment of acute coronary insufficiency. But the prevalence of cardiovascular illness in the British population has gone up equally dramatically because of improved long-term survival rates.

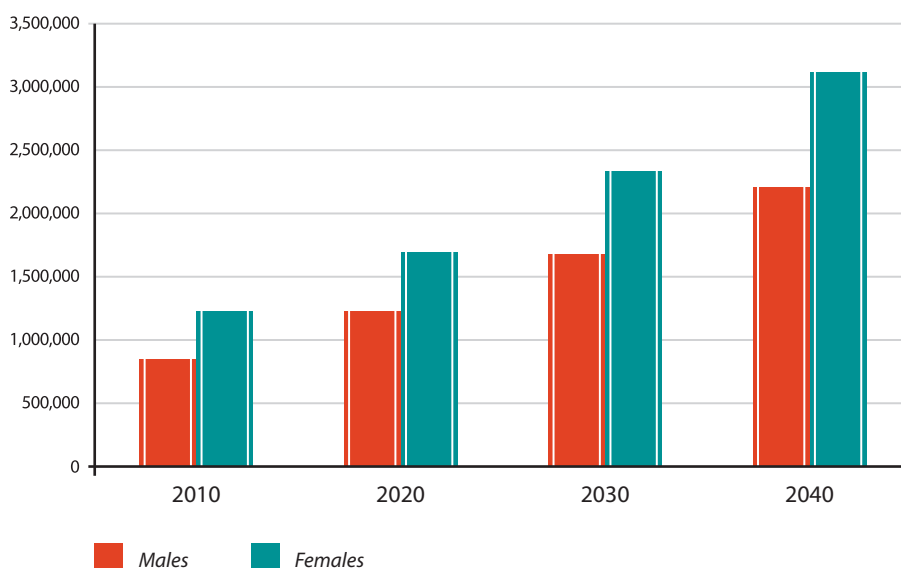
Public health preventive measures are clearly vital to reduce the huge financial strain on the NHS from cardiovascular illness. The statistics from the British Heart Foundation demonstrate that the UK spends nearly £2 billion each year on the healthcare costs of treating Coronary Heart Disease. Also, every seven minutes someone dies of a heart attack in the UK and stroke causes more than 41,000 deaths each year.

Cancer³⁷

As the population ages, cancer incidence is increasing at approximately 2.5 per cent every year. The cost of optimal cancer care has increased exponentially with robotic surgery, precision radiotherapy and new high-cost molecularly targeted drugs. Five new drugs have been licensed in the last two years for prostate cancer, costing in excess of £3,000 a month for only months of survival gain. It is not possible for the current funding for the NHS to keep up with such inflationary pressures for such a common illness with more than 40,000 men becoming new patients each year.

A very significant study, featured in the British Journal of Cancer demonstrated that there are currently two million cancer

Fig. 2 Cancer Prevalence in the UK 2010 - 2040



survivors in the UK, and in recent years this number has grown by 3 per cent per annum. It produced long-term projections of cancer prevalence. Using a model of prevalence as a function of incidence, survival and population demographics, projections were made to 2040. Different scenarios of future incidence and survival, and their effects on cancer prevalence, were also considered. Colorectal, lung, prostate, female breast and all cancers combined (excluding non-melanoma skin cancer) were analysed separately. It concluded:

“Assuming that existing trends in incidence and survival continue, the number of cancer survivors in the United Kingdom is projected to increase by approximately one million per decade from 2010 to 2040. Particularly large increases are anticipated in the oldest age groups, and in the number of long-term survivors. By 2040, almost a quarter of people aged at least 65 will be cancer survivors with their related increased demands on the health service.”³⁸

There are several reasons as to why cancer is so expensive. Just over a quarter of the current expenditure goes on hospital inpatient costs, not including surgery (just the cost of caring for a person in hospital). Almost a quarter (22 per cent) goes on the cost of surgery, and 18 per cent goes on drug treatments (including costs of giving the drug).³⁹ The remainder

of the budget goes on outpatient costs including diagnostic procedures (8 per cent), radiotherapy treatment (5 per cent), cancer screening (5 per cent), specialist services, such as palliative care (5 per cent), and other community services including general practice care (10 per cent).⁴⁰

Over the past eight years, newer technologies have been estimated to add around 3.7 per cent per year to the total cancer expenditure. This rate of increase is expected to apply in the coming decade as well.⁴¹

Arthritis⁴²

Arthritis is the UK's biggest single cause of physical disability, affecting around nine million people. One in five people in the UK suffers from arthritis and an estimated 70 per cent of all 70-year-olds have arthritis. Moreover, nearly three-quarters (72 per cent) of people with arthritis meet the legal definition of being disabled. In total, one in five GP visits involve the symptoms of arthritis, such as joint pain, stiffness, fatigue and impaired mobility. Altogether, arthritis and related conditions are the second most common cause of days off work.

Dementia⁴³

It is estimated that there are more than 570,000 people (1 in 3 aged over 65) with dementia in England, and over the next 30 years that is expected to more than double to 1.4 million. In many cases it's mild and has no real impact on the health system. But severe dementia requires total institutional care and many will live for years. Dementia costs the UK economy £23 billion every year. The combined health and social care costs of dementia are estimated at £10.3 billion in 2008, compared to £4.5 billion for cancer, £2.7 billion for stroke and £2.3 billion for heart disease.

In all, caring for each person with dementia has an economic impact of £27,647 per year.

Depression⁴⁴

Newly-released figures have highlighted the prevalence of mild mental illness among people living in the UK. According to the findings from the Office for National Statistics, nearly one-fifth of adults experience anxiety or depression, with the conditions affecting a higher proportion of women than men. It was shown that the highest incidence of mild mental illness is among the 50 to 54 age group, while 19 per cent of people aged 16 or over reported the symptoms.

Mental health problems, of which depression is the most costly, represent approximately 10 per cent of the UK's total health care costs and result in an estimated £23 billion of lost employment and productivity to the UK economy.⁴⁵

In all, long term conditions are a significant drain on NHS resources and blight the lives of many. Where once polio, cholera and dysentery were the targets of the healthcare system, chronic conditions like those mentioned above must be what the future NHS endeavours to cure. It is vital that we develop systems that are able to deal with these complex conditions and that which prioritise prevention over expensive medicines and surgery. For this to happen, much of our healthcare will need to be better integrated and moved out of hospitals into more appropriate settings.

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4 Mutualism as a real alternative to state and private provision

“Mutualism is naturally based upon inclusive and democratic models. But at the same time, mutual organisations operate in a competitive environment, which brings benefits to patients through improvements in choice and quality.”

The current debate regarding health reform typically fluctuates between arguments for full state control of the system and healthcare privatisation, often through some form of insurance. But neither are by themselves fully sufficient for what the NHS and patients need. The current system safeguards the health needs of all, but is overly bureaucratic and increasingly dehumanising. Equally, completely opening the NHS up to the private sector would allow for the cherry-picking of wealthier patients and would not by itself fix the problem of service disintegration. Mutualism is a viable alternative to pure versions of either of those two approaches. Mutualism is naturally based upon inclusive and democratic models. But at the same time, mutual organisations operate in a competitive environment, which brings benefits to patients through improvements in choice and quality.

As mentioned previously, mutuality is congruent with the founding principles of the NHS. As the English health system is run for the service for the people and already exists in part through the quasi-mutual structures of foundation trusts as public benefit organisations, mutual models of healthcare are completely compatible with NHS principles and existing structures. Indeed, the use of general taxation to fund the NHS is in effect a mutual process.

There are many different types of mutual organisations, but each are defined by their central purpose to serve their members, which could be defined as employees, customers, service users, communities or

other such groups. Examples of mutual organisations include employee-owned, where employees own at least 51 per cent of the organisation; community benefit societies, which are run for the benefit of a defined community and held accountable through democratic processes; or mixed models, such as NHS foundation trusts.

The first NHS foundation trusts were created in April 2004 when ten hospital trusts providing acute healthcare were authorised to convert by Monitor. Today there are 147 foundation trusts spanning the acute, mental health and ambulance service (101 acute health providers, 41 mental health organisations and 5 ambulance trusts). Dedicated community services organisations are also preparing to be authorised as foundation trusts. Foundation trusts were established through the 2003 Health and Social Care (Community Health and Standards) Act 2003, and consolidated into the National Health Service Act 2006. Foundation trusts are part of the NHS and provide services in accordance with its core principles - free care based on need, not the ability to pay.

Foundation trusts are public benefit corporations, a legal form unique to foundation trusts based on mutual traditions. They are led by an independent Board of Directors and are accountable to local communities through a system of local ownership. The public, patients, service users, their families and carers, and staff can join the trust as members and elect governors to represent them. Members and Governors are the centrepiece of the

The advantages of the mutual model

Overall, there are several clear advantages to incorporating more mutuality into the NHS:

- Mutuals can support stable and competitive financial markets through offering an alternative to for-profit delivery organisations that can create market instability due to price fluctuations, and the proliferation of which often results in market dominance by a small number of such firms.
- Mutuals are generally associated with increased employee and customer satisfaction due to employee and customer ownership.
- Mutuals already operate under the founding NHS principle of comprehensive inclusiveness, and are popular with the public because of this.
- Mutuals commit to, and deliver, improved diversity and inclusion through their ownership and governance structures.
- Mutuals are truly customer-focussed and must, by default, act in the interest of their members, be they patients, clinicians or representatives of the wider community.
- Mutual profits are returned only to their members or re-invested for improved services. As such, they are often trusted more highly over purely for-profit organizations

foundation trust's accountability and strong governance. Foundation trusts are also accountable to Parliament, where they must lay their annual reports and accounts.⁴⁶

Taking inspiration from co-operative and mutual societies, the co-operative sector was supportive and involved in the early stages of their development. Their introduction saw for the first time, the concept of grassroots membership for patients and staff in the NHS and provided a model for communities through elected representatives to influence healthcare provision.⁴⁷

As a result, all NHS foundation trusts have a duty to engage with their local communities and encourage local people to become members of the organisation, as well as ensuring that membership is representative of the communities they serve. As part of the application process to become a foundation trust, NHS trusts are required to set out their detailed proposals for the minimum size and composition of their membership. Anyone who lives in the area, works for the trust, or has been a patient or service user there, can become a member of an NHS foundation trust. This gives staff and local people a real stake in the future of their hospital.⁴⁸ Clearly, through foundation trusts, mutualism already has a fully functioning role in the delivery of healthcare.

They are not alone in this regard. Alongside foundation trusts are a multitude of NHS spin-outs. These were developed off the findings of the Social Enterprise Unit, which was established in 2001 by Patricia Hewitt MP (then Secretary of State for Trade and Transport). These spin-outs signalled a breakthrough for employee-led public services and the adoption of co-operation and mutualism in public sector reform. Following Hewitt's appointment as Secretary of State for Health, several Department of Health papers⁴⁹ outlined the potential for spin-out organisations to deliver healthcare services, and signalled the beginning of the Department's Social Enterprise Pathfinder Programme (to support and encourage the development of new social enterprises to deliver health services).⁵⁰

In 2008 Labour introduced the Right to Request Programme, which gave Primary Care Trusts (PCTs) the opportunity to innovate and develop their own organisation's delivery of healthcare. Under this, PCTs were obliged to consider and support spin-out requests; services would then be contracted out from the NHS with a maximum three-year contract and delivered by the spun-out organisation, remaining free at point of use for the public. This formed the first wave of public sector mutuals supported by government

policy, creating 38 spin-outs with around 22,000 NHS staff working with them.

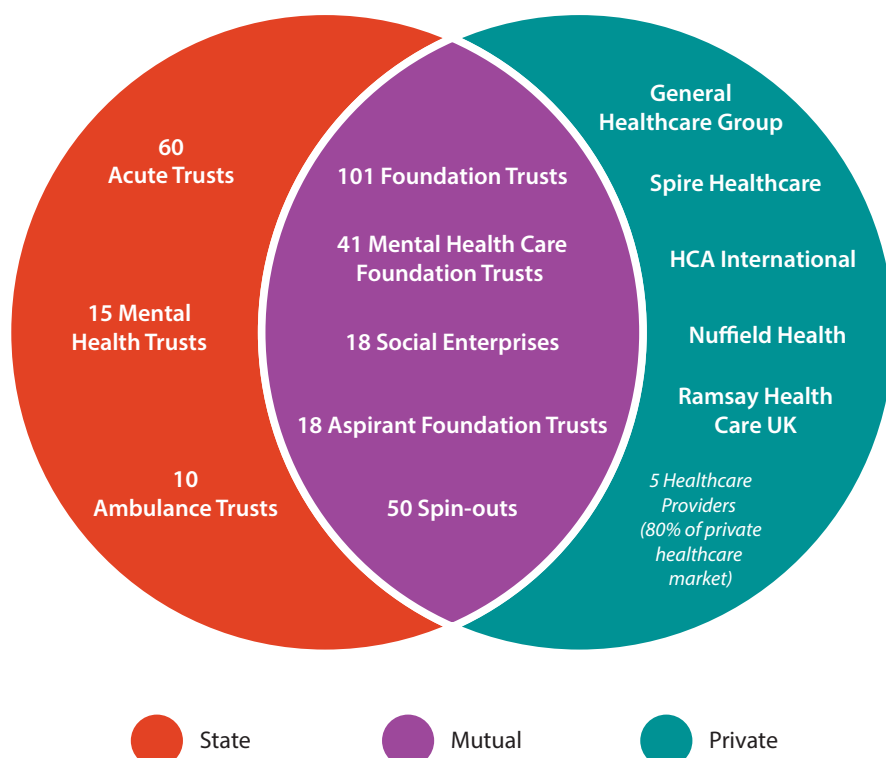
The Coalition Government continued supporting employee-led public sector spin-outs as part of the 'Big Society' agenda. The Mutuals Information Service, supported by the Mutual Support Programme, was created to support public sector workers establishing mutuals. The Right to Provide Programme, which replaced the Right to Request in 2010, allowed for a greater scope of public sector spin-outs beyond PCTs to staff working in acute trusts, mental health trusts, local authority social services and special health authorities. A 2011 Department of Health guide Making Quality Your Business: A guide to the right to provide outlined the government's strategy and was followed in 2012 by £10 million to support the creation of frontline mutual services or social enterprises.

In 2010 the European Commission published "Buying Social: a guide to taking account of the social considerations in public procurement", which encouraged the use of procurement to promote, employment opportunities, social inclusion, accessibility designed for all and general compliance with social standards. Public authorities have always had the power to do this, but it is rarely seriously employed.⁵¹

The Public Services (Social Value) Act 2012 adds to this and presents a framework for reforming public services that emphasises innovation and community engagement, and brings with it an obligation in the pre-procurement stages to consider how the proposed procurement might improve the economic, social and environmental well-being of the relevant area.⁵² It has been argued that the Social Value Act present a significant opportunity for CCGs to prioritise those long term contracts that have an emphasis on integration and community provision.⁵³

The Localism Act 2011 also promotes the idea that there is particular value in service delivery by independent providers closest to the local community. It creates a "Community right to challenge", for public benefit organisations or relevant public service employees (including NHS employees), to the effect that the service may be better delivered by an independent public benefit organisation. By the end of

The Mutual Health Service



2011, the value of public services delivered by dozens of NHS 'spin outs' was £886m, or 12% of the annual turnover of the social enterprise sector in the UK.⁵⁴ Many of these spin outs take some variant of the mutual form,⁵⁵ and, together with foundation trusts, form a solid rump of NHS services that are now mutually governed or owned.

This transition of the NHS from public to mutual over recent years mirrors the experiences in other EU countries. In France, mutuals are very active in providing health services and provide almost 8 per cent of all health coverage,⁵⁶ and in Belgium mutual insurers provide the bulk of health financing and cover through the mutuelles, which are very similar to our own friendly societies. Moving the NHS from a totally publicly owned and governed health service to a hybrid model, with significant mutual representation, simply mirrors what is already the case in much of Europe.

Most hospitals and organisations that deliver healthcare already operate within the mutual sphere.

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5 A mutual model for NHS commissioning

“As has been noted in this report, mutualism is already well-established in many parts of the NHS. But what is missing is a mutual component to the NHS that promotes services integration and is firmly embedded in the healthcare commissioning process.”

In light of the impending financial crunch, comprehensively embracing mutualism in the NHS could prove invaluable. Avoiding the problems that are commonly associated with purely public or private models of healthcare provision would not only prove advantageous from a healthcare point of view, but it could also present a more nuanced approach to health reform that could by-pass the often divisive and confrontational debates that surround the topic.

As has been noted in this report, mutualism is already well-established in many parts of the NHS. But what is missing is a mutual component to the NHS that promotes services integration and is firmly embedded in the healthcare commissioning process. This is sorely needed if integrated, end-to-end care is to provide for the holistic needs of patients.

Recent estimates from the Department of Health have made it clear that, to keep pace with the growing demand for healthcare, the NHS must make savings of up to £20 billion before 2015. This is equivalent to year-on-year savings of 4 per cent. The Department expects at least a fifth of these savings to be generated through service transformation and providing more integrated care and care in the community. When meeting these targets, the Committee of Public Accounts stressed that service transformation holds the key to future NHS savings. For the Committee, service change in large part includes better integrated care and providing more services in the community.⁵⁷

Monitor defines integrated care as care and support that is person-centred and co-ordinated.⁵⁸ The best means of achieving this is through improved health commissioning processes. Because of this, we recommend that the Department of Health instigate a review of patient empowerment and engagement. This review would build on the Review initiated by Norman Lamb MP, Minister for Care and Support, and led by Chris Ham on NHS staff engagement.⁵⁹ This review would consider options for supporting the patient voice in the running of NHS services through the introduction of more mutualism to the system, and would assess the wider role mutual organisations could play in empowering patients.

The current commissioning landscape

Under the new NHS structures, Clinical Commissioning Groups (CCGs) are responsible for commissioning health services for patients in their respective areas. All healthcare commissioners, including CCGs, are subject to the Procurement, Patient Choice and Competition Regulations. These regulations were introduced as part of the reforms that are contained within the Health and Social Care Act 2012, and were intended to improve commissioner flexibility by introducing a principles-based approach to commissioning. This approach differs from the previous approach by containing fewer prescriptive rules on how commissioners must carry out the procurement process.⁶⁰

Significant freedoms were granted to NHS commissioners as part of these reforms, and these freedoms are, in the round,

In the guidelines outlined by the regulator Monitor, it has been made clear that it is for commissioners to determine what exact services to procure for patients. However, the regulator was keen to stress that, when making these decisions, commissioners should make balanced judgments based upon a range of local factors, and stressed, as part of this assessment, that the introduction of competition is only welcome when it is proven that it will serve the needs of patients.⁶¹

Under current commissioning guidelines, the new principles commissioners should follow include:

- To secure the needs of patients who use NHS services, and to improve the quality and efficiency of those services;
- To act transparently and treat providers in a non-discriminatory way;
- To procure services from providers that are most capable of delivering the overall objective and that provide the best value for money;
- To consider ways of improving services through service integration.⁶²

Current guidelines clearly stress the importance of service integration, and ingrain into commissioners a sense of purpose that is inclusive of innovative models for delivering healthcare, such as mutuals and third sector organisations.⁶³ Under the Health and Social Care Act, Monitor has a duty to “enable” integrated healthcare.⁶⁴ But under the NHS Provider License, this so far only extends to allowing Monitor to intervene where providers are acting in a manner that is detrimental to the integration of care.⁶⁵

As service integration will become increasingly significant as the decade progresses, we believe that this passive approach to regulation should be replaced with a far more pro-active one. We recommend that Monitor be re-cast as the regulator for NHS integration, and that it should proactively police levels of healthcare integration. One possible option for regulating the sector in this fashion could be through Ofsted like inspections and grading. Another could

Case study 1: A system-wide approach in Northern Ireland

In 2011 a review of the provision of health and social care services in Northern Ireland was carried out to develop a new strategy. Transforming Your Care was published in December 2011 on the back of this. The development of an integrated care partnership was the main thrust of the strategy for health commissioners. There were numerous issues as to why a more integrated system for healthcare was essential in Northern Ireland. For instance, there were difficulties in identifying patients with long-term conditions; there was no single view of patient medical information; no patient care episode plan; and a medical model that had remained unchanged for more than a century. Five clinical priorities were identified as part of this strategy:

- Frail elderly
- Respiratory disease
- Diabetes
- Stroke
- End of life care

On the back of this, integrated care pathway partnerships were developed. Service improvement networks were embedded in the delivery system covering 25 general practices, with approximately a 100,000 population, based on the geography. Multi-professional groups were developed between the acute sector community and primary care and all GP practices became part of the partnership. Sophisticated metrics are now in place to measure the success of the programme in terms of the number of unscheduled hospital bed days; process time; the clinical key performance indicators; the cost effectiveness; and patient perception. This all makes the healthcare services much better integrated and appropriate.

be through publishing comprehensive league tables that compare CCGs against one another. Either way, we believe that Monitor needs to take a much more active role in service integration, and should measure the performance of CCGs in a comparative fashion.

Prime and alliance contracting

But perhaps the most innovative development to emerge regarding NHS commissioning in recent years, at least with regards service integration, is the concept of prime or alliance contracting.⁶⁶ These are types of NHS commissioning contracts that have emerged only recently in the NHS, and have the potential to dramatically improve the quality of healthcare provision across the board.

The prime contractor model makes it possible for commissioners to access the expertise of a consortium of partners, each with a specific specialism, while only contracting with a ‘prime’ contractor for

the organisation of a whole care pathway. The prime contractor may or may not be the main service provider, their key role as a prime contractor is to ensure the integration of services and the delivery of outcomes. Alliance contracting operates on a similar basis, but are operated through a consortium or as a joint venture, with these partners together acting as the ‘prime’. Both approaches are, however, good ways in which a commissioner could be empowered to ensure that healthcare is delivered according to patients’ needs, rather than fitting existing patient pathways across individual providers in a confusing manner.⁶⁷

There is one key case study often cited as a well-functioning example of prime contracting. Circle, itself a mutual, has a contract with Bedfordshire CCG to deliver integrated musculoskeletal services. This was the first example of this type of contracting, with Circle being financially and clinically accountable to commissioners for the whole pathway.

Case Study 2: The democratic and patient-led nature of Benenden Health

Member Engagement

Members engage with Benenden Health on a regular basis through the following channels:

- **In Person** – Local branch meetings present an opportunity to meet with fellow members, receive information and discuss relevant issues.
- **Online** – Visiting the online community in the members' area of the website or via social media and email with the branch Society Secretary.
- **Post** – Writing to the Society Secretary.

Benenden Health regularly provides members with information about services, governance and future strategy. Regular editions of *benhealth* (the organisation's magazine), invitations to branch meetings and information about how become involved in member activities are also disseminated.

Democratic process

Local Branches

Local branches are groupings of members that form the democratic structure by which members are able to have a say in how the organisation is run.

Each branch is run by a committee of volunteers and holds several general meetings throughout the year. This is the mechanism through which members elect a delegate to represent the views of the branch at Conference and vote in their interest. The number of delegates a branch may elect depends upon the size of the branch.

National Conference

Conference is held each June in order to receive statutory reports, debate and agree changes to Memorandum and Rules and consider other propositions such as suggestions for new services. Elected delegates vote on propositions but all members may attend as observers.

Elections for Conference positions take place at various intervals. Positions available include:

- *The Committee of Management* - responsible for the strategic direction of the organisation.
- *The Society Secretary* - responsible for the management and administration of the democratic structure.
- *Standing Orders Committee* - responsible for making recommendations on how to efficiently deal with Conference business.
- *National Appeals Committee* - responsible for hearing appeals from the Committee of Management.

Through these structures, Benenden Health continually engages with its members and promotes patient empowerment through its democratic process.

This step towards a more integrated system utilising the prime contractor model has been lauded as an innovative and imaginative commissioning solution, and there is evidence that more CCGs are moving towards this and similar models.⁶⁸

Because of the transformative revolution that prime and alliance contracting could initiate in the NHS, we recommend that CCGs prioritise these commissioning agreements over others. To achieve this, we recommend that NHS England amend the NHS Standard Contract to make these forms of contracts the standard modes for commissioning. All new NHS contracts for the provision of healthcare should have integration at their heart. Prioritising these types of contracts would promote more collaborative approaches to healthcare and enable holistic care to take place.

As well as the general benefits these contract types could bring, they also present an invaluable opportunity to mutuals in the NHS, and in particular friendly societies. These organisations are mutual organisations run for the benefit of their members, who pay into a mutual fund to access certain services procured by the mutual. Before the advent of the National Health Service, most funding for healthcare services was provided through friendly societies. Just before the onset of the Great War, there were 26,877 friendly societies operating in England and 6 million members, over 10 per cent of the population at the time.

The democratic and inclusive characteristics of these organisations would make them ideal as a prime contractor. Being a prime contract requires the body in question to operate in a collaborative manner with partners in the industry. Friendly societies are naturally co-operative organisations, but not only this, most friendly societies that operate in the health sector already utilise a similar commissioning model. Friendly societies do directly provide healthcare to their members, but most of the healthcare is provided via partnering organisations, which are either private or charitable. Under current models, friendly societies operate as the repositories of a mutual fund, held accountable to their members through democratic processes. In this way, they provide the financing for healthcare,

but not necessarily the provision. For providing the integrator role that this report advocates, such an operating model makes friendly societies ideal.

On top of this, using friendly societies as the prime integrator in the commissioning process would empower patients. As it stands, patients are often referred on to NHS services by their GP in a confusing and disjointed manner. Patients often experience multiple referrals to disparate providers and in a multitude of settings. Referring patients in this manner is inefficient, wastes time and is detrimental to the overall patient experience.

Our health system's inability to assess patients' needs correctly causes a huge strain on the NHS. The effects of this is seen predominantly in Accident and Emergency (A&E), where limited resources are dedicated to patients whose afflictions should have been addressed earlier along the line, in a setting that would be better suited for both patient and health system. For example, a recent study demonstrated that 80 per cent of A&E admissions (of those hospitals that participated in the study) were admitted for non-emergency or irrelevant reasons. In other words, four out of five of those seen in A&E should not have been there, but their ailments had not been solved correctly elsewhere in the NHS.

The same study demonstrated the extent of the strain on A&E with almost half available resources being consumed by only five per cent of patients.⁶⁹ This failure demand, demand created by a failure to do something properly the first time round, is demand that should not exist and is devouring finite NHS resources. Friendly societies would, therefore, as the prime integrator in the transition of the post-referral patient through the healthcare system for those with complex conditions, be perfectly placed to deliver the holistic and integrated care needed to ward off this failure demand.

Moving towards a more integrated system

The benefits of integrated healthcare are many and varied. Shifting services out of hospitals to more appropriate settings would help patients avoid unwanted

Case study 3: Harnessing the power of academic medicine

There are many major hospitals in North West London catering for the health needs of a population of 2.3 million people. In order to effectively cater for the diverse needs of such a large population, these hospitals have established an umbrella organisation to help co-ordinate healthcare services – Imperial College Health Partners. This organisation aims to provide integrated care pathways by joining up eight hospital trusts, two mental health trusts, one community health trust, eight CCGs and Imperial College, one of Britain's leading universities.

An ageing population with huge swathes of deprivation mixed with some of the wealthiest suburbs has resulted in a 17 year difference in life expectancy across the area. There are huge variations in the standards of care provided and a mismatch in its provision. As a result of the previously disjointed system, the rate of adoption of new innovations and best practice demonstrated enormous differences. As part of the new strategy, eleven projects are now underway - five focusing on specific clinical conditions and six cross-cutting projects focusing on system issues as a whole. These include:

- Cardiovascular rehabilitation
- Cancer
- Chronic obstructive pulmonary disease
- Neurorehabilitation
- Mental health

Early evidence suggests that this embryonic organisation is starting to change and improve the way health care is delivered for the whole area.

hospital visits. It would also enable clinicians to develop a more holistic view of patients' needs and allow for greater personalisation in the way care is delivered.

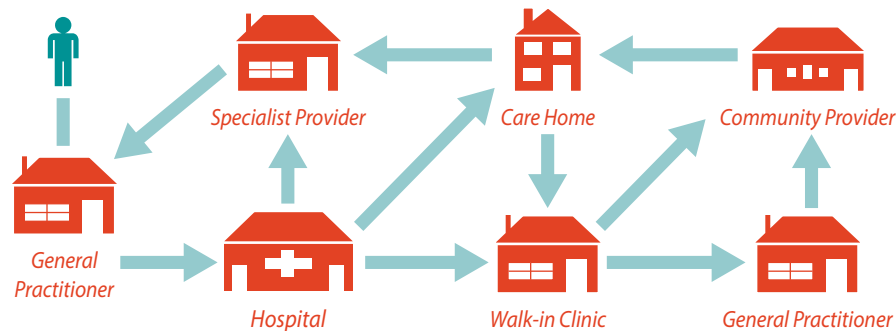
But NHS integration, despite all the well understood benefits, is still a distant dream. The NHS system remains fractured and the delivery of healthcare siloed, particularly in acute settings. The advent of Clinical Commissioning Groups (CCGs) presents a possibly vital opportunity. These organisations dominate NHS commissioning and are completely GP-led. As such they are perfectly placed to initiate the integration revolution. Unfortunately, under current commissioning arrangements, CCGs have most of their contracts locked-up in hospital and acute settings. Many health commissioners are fully aware of the benefits of shifting services out of hospitals to the community, but lack the path or organisations through which to activate the decommissioning process and actually move these services.

In addition to this, many of our best community and specialist health providers sit outside current NHS structures. For these, CCGs for the most part do not have comprehensive commissioning agreements and external provision is generally excluded from most NHS patients. Also, the provision of private healthcare, whether funded from NHS budgets or through private insurance, is just as siloed as the NHS structures it sits parallel to and does not present the means through which to integrate primary and secondary care.

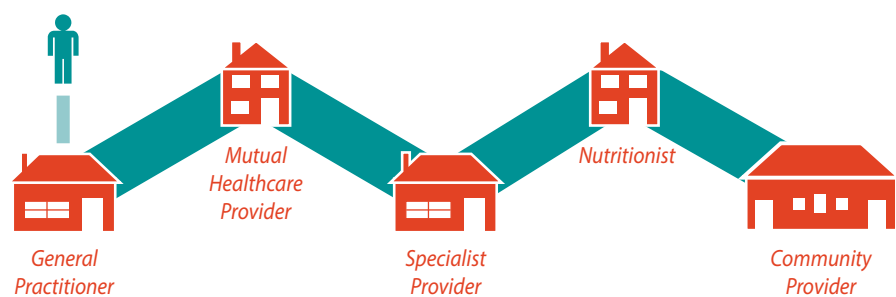
To remedy this, new aggregator institutions for healthcare service delivery need to be developed that sit outside present NHS and private health structures. These new institutions would need to operate in a facilitating capacity to deliver high quality holistic care regardless of whether that care is provided by NHS bodies, private firms or mutual spin-outs. To fully integrate patient care pathways, these new integrator institutions need to be fully partnered with

Patient Pathways

Current referral system



Whole-person care plan



care through the introduction of Personal Healthcare Budgets (PHBs). A personal health budget is an amount of money that is attributed to you for particular health needs for a specified amount determined by discussions between the patient and clinicians.

Following a successful pilot study into the feasibility of PHBs, the Minister of State for Care Services, Norman Lamb MP, announced the national roll out of PHBs in November 2012. This followed a three year pilot programme in the NHS (which ended in October 2012) and the publication of an independent evaluation report led by the University of Kent. Patients who are eligible for NHS Continuing Healthcare, the bulk of which is comprised with those with LTCs, now have a right to ask for a PHB from their GP. It was also announced that Clinical Commissioning Groups (CCGs) will also be able to offer personal health budgets to others that they feel may benefit from the additional flexibility and control,⁷⁰ which opens up the potential for using PHBs for the commissioning of services provided by mutuals.

community and acute providers. Doing so in such a comprehensive fashion would undoubtedly both improve NHS cost effectiveness and enhance health outcomes.

It is clear, given the unique demands of this new role within an integrated system, that these new bodies would need to partner with a diverse range of bodies in an inclusive and collaborative fashion. Because of these particular demands, the only type of organisation capable of performing such a role would be a friendly society, which, as was discussed above, are run for the mutual benefit of all those involved. Just like NHS bodies, these organisations are not purely concerned with the profit motive, but unlike NHS bodies, mutuals are completely independent from state control and operate in a competitive market. This position in the health sector makes mutuals the ideal candidates for assuming a central integrator role amongst the chequerboard of NHS bodies and private providers.

Friendly societies provide support to their members through a discretionary mutual fund. The services that mutual societies provide are, because they are completely discretionary, intended to complement rather than replace NHS services. As such, they are only activated once it is clear that a service could be provided more effectively outside of the NHS. Because of this, mutual insurers are perfectly placed to fulfil the facilitating and integrating role the NHS needs, and to not act in a predatory manner towards existing public health services.

The place of personalised care

Delivering personalised and holistic healthcare is the Holy Grail of health reform. Until recently, the funding mechanisms within the NHS made it next to impossible to differentiate between individual patients for specific NHS treatments. This problem has now been largely done away with in continuing

As the amount allocated to a PHB is agreed between the person in need and their local NHS team, it enables people with long-term conditions and disabilities to have greater choice, flexibility and control over the health care and support they receive. Early evidence from personal health budget implementation suggests that they do just this, and could play a significant role in the future of healthcare funding. Research commissioned by the Department of Health further evaluated the PHB pilot programme. As part of this, it assessed whether personal health budgets are a cost effective solution and whether they improved health outcomes. This study found PHBs were good value for money relative to conventional service delivery. Further, the review highlighted how PHBs produced higher care-related quality of life measured net benefits.⁷¹

Personal Healthcare Budgets offer people the opportunity to take further responsibility for their own health. The next step is to assess how PHBs could be utilised by external providers in the private, mutual and voluntary sectors. For the model proposed in this report, PHBs present the perfect opportunity through which to

increase choice and competition through opening up NHS budgets to external providers. For any commissioning agreements determined between health mutuals and CCGs, Personal Healthcare Budgets would seem the ideal vehicle to untangle NHS spending for release to the market. The model in this paper would, through the use of PHBs, empower patients and clinicians, whilst at the same time saving the NHS significant amounts of money through more efficient processes and more sophisticated funding mechanisms.

These budgets would also open up the possibility for GPs, in partnership with patients, to develop clearly determined Whole-Person Care Plans. As it stands, much of the healthcare that is delivered is fractured, with patients suffering from the complex conditions associated with old-age and ill-health having to visit a multitude of different clinicians in various health settings. Under a Whole-Person Care Plan, a patient with chronic and complex conditions would, instead of being artificially siloed into a multitude of different healthcare settings in a disconnected fashion, receive a plan that would supply the patient with a coherent and seamless pathway through the health system.

These plans would allow the patient, many of whom are older people, to request the establishment of a personalised patient journey map that would set out in clear detail the integrated network of services the patients would be able to access, and arrange the referral of that patient through the system in an efficient and stress-free manner. These Plans should in turn be delivered through Personalised Healthcare Budgets to allow for further streamlining.

Friendly societies, because they are democratic institutions that factor in the holistic and diverse needs of their members by default, would be very well placed to enable GPs to design Whole-Person Care Plans for their patients. This would allow for better personalisation in NHS services and would dramatically reduce failure demand – thus taking the strain off other NHS services such as A&E departments.

Whole-Person Care Plans would fit very well aside the Government's current Integration Pioneer Programme. This is an initiative

established at the behest of Norman Lamb MP, Minister for Care and Support. Fourteen initiatives have been announced, and the aim is to make health and social care services to integrate better to provide more support in the community and deliver joined-up care.⁷² They should enable commissioners to shift the focus of practice from providers and individual interventions to a more integrated journey for the patient. Whole-Person Care Plans could be something that these pioneers could trail-blaze to ease the transition of patients through the healthcare system.

But it must be noted that not all patients would be able to access the support provided by friendly societies acting as prime contractors. Because of this, we would recommend that the Government legislate for a new Right to Holistic Care. This new Right would be activated by the patient to increase user empowerment, and would require GPs to provide Whole-Person Care Plans for those who do not want to navigate the confusing and often bewildering array of different options that may confront them post-referral. Instead, the activation of this new right would require GPs, and through them CCGs, to design more integrated healthcare services. In this way it would represent a significant increase in patient empowerment, and would further hasten the shift towards greater service integration.

How a mutual system of integrated care would be funded

The consensus in the health sector is that shifting contracts from acute to community settings, and integrating these services, would amongst other things, improve health outcomes for patients, increase patient satisfaction and be much more cost effective.⁷³ This report argues for a mutual model of healthcare integration that allows for care to be delivered in a more holistic manner. But, in light of overarching cuts to public expenditure and the impending NHS funding gap, it is essential that any new system performs this function without adding to financial burdens.

The current drive for efficiency saving within the NHS has been driven by Department of Health targets outlined in the Quality, Innovation, Productivity and Prevention (QIPP) initiative. This programme of reform

is committed to finding £20 billion worth of savings before the end of this Parliament and outlining where further savings can be made over the next decade.

The commissioning side of the NHS has not been exempted from QIPP, and CCGs are under intense pressure to make significant cost savings. For the financial year 2013/14, CCGs made on average efficiency savings worth 2.7 per cent of total allocation.⁷⁴ Given that the average budget for each CCG is £286.9m,⁷⁵ this amounts to an average saving of £7.7m for that financial year for each CCG.

It is our intention that the financing for the posed mutual fund for healthcare integration be paid for out of current efficiency savings rather than from additional financing. In this way, the initial commissioning of the respective health mutual will be at least zero-sum for CCGs. When establishing whether the proposed scheme would be affordable to CCGs under current QIP requirements, we determined the average amount of people with LTCs in each CCG and then the standard cost for purchasing mutual health insurance with a health mutual for that person. The results were then extrapolated out to determine the average overall cost to CCGs for investing in a mutual fund for holistic care.

As stated previously, current estimates suggest that as many as 15 million people currently have at least one LTC – 28.3 per cent of the population.⁷⁶ Given the average CCG population is 251,700, on this basis, and by calculating an equalised average, one could expect that 71,231 people in each CCG area will have at least one LTC.

To determine the costs to the taxpayer for investments in a mutual fund, the industry average cost per annum would also need to be determined. For this we took the top five leading health mutuals and calculated the mean average.⁷⁷ This amounted to £103.92 per member per annum. So the average cost to each CCG for investing in a mutual fund would be £7.4m per annum, which still leaves a saving on £0.3m per annum on current QIPP trajectories. Under the proposed model advocated in this paper there would appear to be room within the current NHS efficiency drive for investment in a mutual fund without additional burdens being placed on the

taxpayer. To establish the viability of using CCGs in such a manner to procure mass mutual membership in friendly societies for the provision of integrated care, we recommend that the Department of Health establish a Pilot Scheme for this assessment of this model where CCGs are comfortable meeting their QIP targets. This scheme would need to be no larger than 8-10 CCGs to begin with.

Utilising the mutual model proposed in this report and using CCG funds to invest in friendly society-held mutual funds, would mean NHS patients could then access the additional services that friendly societies provide to their existing members. But to expand this offer, and we strongly suggest that they do, we recommend that friendly societies increase their current product offer to include a more varied range of services, and that they form partnerships with a broad range of hospital-based and community-based organisations as part of prime contracting arrangements. Accountability and transparency for this care pathway would then be maintained and overseen by the CCG through the creation of such a contract.

Under this model, it is also vital that friendly societies themselves are subject to healthy competition. The Association of Financial Mutuals, which represents friendly societies, comprises of 53 full members. The majority of these members do not provide cover for health services, and instead focus on pensions and savings. To promote competition amongst friendly societies in the NHS, we recommend that many friendly societies adjust their product offers to make them more suitable to the health market. This would both increase competition amongst mutuals and improve patient choice.

The benefits of a utilising this model to patients and to the NHS

Of course, current trajectories in health expenditure do mean that additional savings would have to be made in addition to these efficiencies. It is envisaged under these reforms that the bulk of these savings would be generated through utilising the NHS mutual funds to provide more holistic care in the community rather than in acute settings, and through the superior integration of healthcare services in general.

There isn't a single definition of service integration, but the common denominator to any approach is the inclusion of an attitude to healthcare delivery that seeks to improve the quality of care by ensuring services are co-ordinated around the needs of the patient, carers and other service users. Crucial to delivering integrated care is taking the perspective of the user as the organising principle of delivery and targeting this care to those that need it most.⁷⁸

Monitor recently published a review on what savings could be made by initiating better service integration. The regulator suggested that the NHS could achieve an overall productivity gain worth £2.5bn - £4.2bn (average - £3.35bn).⁷⁹ This mirrors the findings of a Confederation for British Industry (CBI) report that established that £3.4bn could be found per annum,⁸⁰ and a NESTA report that calculated as much as £4.4bn could be saved each year.⁸¹ The Monitor review will, however, be used as the prime basis for ascertaining whether any potential cost savings could be generated by utilising the model described in this report. This is solely because this review conducted the most detailed analysis and had available the most accurate data.

The savings from the Monitor report were broken down into a number of headings. The most minor amount of savings would be made through better estate utilisation. By directing more funds towards community health services, providers would be encouraged to upscale to produce certain economies of scale within community care. Through increasing the capability of the community health sector through better estate utilisation, it is estimated that this could save the NHS up to £200m per year.⁸²

These savings, while not insignificant, are not much when compared to the huge savings that could be generated in other areas. The biggest gain to be had would be through preventing unnecessary hospitalisations through more integrated care. This could save the NHS up to a staggering £2bn per annum.⁸³ Productivity gains from shifting from acute to the community would be generated by managing those with chronic conditions in a much better fashion. This would largely be driven by the better sharing of information and using multi-disciplinary teams spanning providers in primary and community care to

provide more whole-person care. It would also in turn reduce emergency hospital admissions from those with chronic or complex conditions. In 2011, there were seven million unplanned admissions into acute care. This cost £14.5 billion and was typically made up of patients with co-existing long-term health conditions.

As has been argued through this report, the right setting for care for many of those who are frail or elderly is not in a distant hospital, but in the community. Monitor estimate that up to £1.6bn could be saved per year by shifting acute activity to the most cost-effect and appropriate setting. Moving consultant-led activities for outpatients with LTCs alone could alone save £700m, and teaching patients to manage their own care at home could save £400m. But most important, and this is particularly pertinent giving consistent worries on over loaded A&E departments, up to 40 per cent of admissions to A&E could be seen in the community with no detriment to the patient.⁸⁴

Service integration, as a whole, has been associated with a wide range of improvements in health outcomes. Integrated systems of health have shown to produce the following outcomes:

- *Older Care* – Care services for older people in Torbay have reduced the daily number of occupied beds by approximately 250 over the past decade and negligible delayed transfers of care⁸⁵
- *Diabetes* – Integrated diabetes services in Bolton have produced high levels of satisfaction from patients and staff, as well as reporting regionally low number of hospital bed days per person with diabetes.⁸⁶
- *Stroke* – The pan-London stroke care pathway and the development of hyper-acute stroke unites has seen 85 per cent of high-risk patients seen within 24 hours and 84 per cent of patients spending at least 90 per cent of their time in a specialised stroke unit.⁸⁷

Utilising the model proposed in this report would both generate significant cost-savings for the NHS and improve health outcomes for patients.

A privatised alternative to the proposed mutual model

There are alternatives to the mutual model proposed in this report. The Government's flagship scheme for increasing patient empowerment has been the Any Qualified Provider (AQP) programme. Private providers that deliver NHS services do so under this programme, which permits them to provide basic NHS services including physiotherapy, dermatology, hearing aids, MRI scanning and psychological therapy.

The aim for AQP scheme is to allow patients, for some conditions, to choose from a list of approved providers, such as hospitals or high street service providers. These services will remain free for patients to use and access to them,⁸⁸ and will be determined under commissioning agreements between CCGs and the qualified provider.

The whole basis for introducing AQP was to open up services and improve patient choice. At a first glance, the programme seems to have achieved this, with 105

firms signed up to the scheme in 2013.⁸⁹ But instead of opening up service to small, local providers, the process has been criticised for providing the biggest wins for larger health providers, such as InHealth, Specsavers and Virgin Care. A study of AQP found that 24 of the 105 firms were large companies with at least 250 members of full-time staff.⁹⁰ Not the local and community revolution that was promised and what the NHS clearly needs.

On top of this, and in the face of the drive for more integrated care, critics of AQP argue that the process atomises and fragments care, which could undermine patient safety.⁹¹ It also flies in the face of moves towards holism in care. Instead of provided whole-person care, splitting the provision of care into multiple different providers would require patients to see a multitude of providers for interconnected conditions rather than dealt with holistically in the community. In this way, it will simply destabilise existing serviced and damage integrate care pathways,⁹² and potentially add to the overall cost of healthcare through the duplication of services.⁹³ Given that AQP does not cure

the problem of service fracturing, this approach would not be our recommended model for improving health outcomes and integrating NHS services.

Instead, we recommend that the Department for Health evaluate the effectiveness of this scheme. If AQP is viewed to be detrimental to NHS service integration, then we recommend that it be replaced by a more appropriate scheme. Competition and choice are to be welcomed, but they should not come at the price of collaboration and holistic care.

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6 Conclusions and recommendations

“The model we propose in this report would lead to further health service integration and empower patients. Utilising friendly societies in the way envisaged in this report would improve health outcomes and allow for much greater efficiencies to be made. So that long-term conditions and those conditions associated with ageing will not bankrupt the NHS as current forecasts predict.”

As had been re-affirmed throughout this report, the NHS is at a turning point. The problems associated with an ever-ageing mean that England's system of healthcare is simply unsustainable. If we are to successfully defeat the chronic diseases and complex conditions of the future, a significant step-change is needed in the way in which we fund and deliver healthcare. Those conditions and diseases associated with ageing and flawed lifestyle choices, unlike the acute diseases of the past, will require much more integrated systems of healthcare.

This new system of healthcare would deliver holistic care in a personalised and cost-effective manner, and would need to avoid the same levels of bureaucracy that have plagued previous attempts at health reform. In order to achieve this, new ways of integrating healthcare will need to be developed and new institutions that can manage these integrated pathways established. Such a transition is absolutely critical to tackling complex and long-term conditions, and to providing whole-person care.

Throughout this report, we have advocated mutualism as an alternative to both public and private healthcare provision. As mutual organisations are natural both competitive and collaborative, they represent the perfect compromise between public and private provision. Indeed, friendly societies in particular operate on a model that could be particularly advantageous to the commissioning of healthcare services if were suitable supported as advocated throughout this report.

The model we propose in this report would lead to further health service integration and empower patients. Utilising friendly societies in the way envisaged in this report would improve health outcomes and allow for much greater efficiencies to be made. So that long-term conditions and those conditions associated with ageing will not bankrupt the NHS as current forecasts predict.

In order to achieve the more integrated system of healthcare desired by this report, we recommend that Government and the industry adopt the below eight recommendations.

1. Instigate an independent review on patient engagement: Building on the Review initiated by Norman Lamb MP, Minister for Care and Support, and led by Chris Ham on NHS staff engagement, we recommend that the Department instigate a similar review on patient engagement. This review would consider options for supporting the patient voice in the running of NHS services, and would assess the role mutual organisations could play in empowering patients.

2. Establish a Pilot Scheme for the proposed model for integrated healthcare commissioning: We believe that friendly societies, and other mutuals, could play a valuable role in integrating healthcare services. In order to assess the viability of the proposed mutual integrator model proposed in this report, and to evaluate its efficacy in providing better holistic care, we recommend that the Department of Health establish a Pilot Scheme comprised of 8-10 CCGs to determine just this.

3. Re-cast Monitor as the regulator for health service integration: Under the Health and Social Care Act, Monitor has a duty to “enable” integrated healthcare. But under the NHS Provider License, this so far only extends to allowing Monitor to intervene where providers are acting in a manner that is detrimental to the provision of integrated care. Given the forecasted sharp rise in complex conditions and the increasing need for more integrated care, we believe that this passive approach to regulation should be replaced with a more pro-active approach. We recommend that Monitor be re-casted as the regulator for NHS integration, and that it should proactively police levels of healthcare integration. It could do this either through Ofsted-like inspections and grading; or through well-publicised league tables.

4. Require all CCGs to prioritise prime or alliance contracts: The fracturing of the NHS services along bureaucratic lines artificially atomises the needs of patients and ultimately makes holistic care more difficult. To combat this, we recommend that NHS England amend the NHS Standard Contract to ensure that integrated commissioning arrangements, like prime or alliance contracts, are the preferred form of arrangement. All new NHS contracts for the provision of healthcare should have integration and partnership working at their core. Prioritising these types of contracts would both promote more collaborative approaches to healthcare and enable holistic care to take place.

5. Introduce a new Right to Holistic Care: Patients are often referred on to NHS services by their GP in a confusing and disjointed manner. Patients regularly experience numerous referrals to disparate providers and in a multitude of settings. Referring patients in this manner is inefficient, wastes time and is detrimental to the overall patient experience. In circumstance where patients do not feel that they are receiving a fully integrated service from the NHS, we recommend that they be permitted to activate a new Right to Holistic Care. This would allow the patient, many of whom are older people, to request the establishment of a personalised Whole-

Person Care Plan that would map in clear detail the integrated network of services the patients would be able to access, and arrange the referrals of that patient through the system in an efficient and stress-free manner. These Plans could be delivered through Personalised Healthcare Budgets to allow for further streamlining.

6. Scrap the Any Qualified Provider initiative: This leading private provider scheme allows external providers to deliver basic NHS services, such as physiotherapy and psychotherapy. The AQP initiative is promoted in the name of competition and patient choice. Whilst this is admirable, it does not do little to deal with the issues surrounding service disintegration, and, because AQP merely replicates the divisions already present in the NHS in the private sector, it does not allow for the provision of whole-person care. We recommend that the Department of Health evaluate the effectiveness of this scheme. Competition on the whole is something to be promoted in the NHS, but not at the expense of collaboration and integration. If AQP is assessed to be overall detrimental to service integration, as we suspect it is, then we recommend that it be scrapped and replaced with a more appropriate scheme.

7. Issue a challenge to friendly societies to diversify their services: Friendly societies that operate in the health sector offer a mixed-bag of services to their members. Some focus on delivering services to older people and some prefer to focus on wellbeing in the community. In order to operate in the integrator role we recommend in this report, friendly societies will need to increase the amount of services they provide. In order to achieve the role we lay out for them, we request that friendly societies in the health sector re-shape themselves as organisations that primarily focus on providing care for older people and those with long-term conditions.

8. Encourage friendly societies from different sectors to enter the health market: The Association of Financial Mutuals, which represents friendly societies, comprises of 53 full members. The majority of these members do not provide cover for health services, and

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Conclusion and Recommendations

instead focus on pensions and savings. Friendly societies have a long and distinguished history of operating in the health sector, and were, prior to the advent of the NHS, the primary vehicle for health funding. We recommend that friendly societies endeavour to re-discover this role by adjusting their product offerings to make them more suitable to the health market. This would both increase competition amongst mutuals and improve patient choice.

We believe that adopting these above recommendations would significantly improve the integration of NHS services and ensure that our healthcare system will be able to meet the financial and health demands that would otherwise render the system unsustainable.

Models and Partnerships for Social Prosperity

This publication is an output of ResPublica's Models and Partnerships for Social Prosperity workstream, one of the three core workstreams of the ResPublica Trust.

To radically change social and economic outcomes, we need to establish hybrid partnerships between communities, businesses and the public sector, which move beyond the state vs. private sector debate and harness the advantages of both. From creative solutions for localised social care and education delivery to the benefits of community-owned energy and community-run housing associations, this workstream looks at innovative models for public service delivery and private enterprise.

Current and forthcoming work will build upon the ideas outlined in our past output which have had a continuing impact on the British policy landscape. In 2014 this workstream will encompass our research on housing, community energy provision, health and social care, welfare, education, employment and skills.

About Benenden Health

Founded in 1905, benenden health is one of the UK's longest serving and most respected mutual healthcare societies. benenden health has a membership of around 900,000 across the UK and provides over £63 million of healthcare services to its membership community. benenden health offers affordable, discretionary healthcare services that complement rather than replace the care offered by the NHS. Members can request access to a range of healthcare services, with no exclusions for pre-existing medical conditions or upper age restrictions. The organisation is passionate about the value of mutuals in society and the role that they can play in transforming public services and individuals' lives.

The National Health Service, one of society's most valued institutions, is in severe financial jeopardy. Shrinking health budgets, together with an ageing population and a rise in those suffering from lifestyle diseases, mean that the NHS in England is simply unsustainable. Long-term conditions will alone bankrupt our healthcare system unless drastic reform is undertaken to plug the £34 billion funding gap that will exist within a decade.

Power to the People: The mutual future of our National Health Service argues that the key to saving one of our most valued institutions would be to move away from the bureaucratic and fragmented health system we currently have, towards an integrated system of healthcare provision that makes it possible to offer whole-person, holistic care to patients. This report highlights the valuable role mutuals could play in integrating disparate public, private and third sector bodies to both improve patient outcomes and plug the impending funding gap.

This report firmly establishes the need for an integration revolution and outlines how the future of our NHS will need to be much more mutual if we are to keep the NHS free at the point of use.



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